Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHIROTECH CHIROPRACTIC
4830 SOUTH FREEWAY
FORT WORTH TEXAS 76115

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

FEDERAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-0009-01

MFDR Date Received

August 31, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Extemity [sic] Manipulation is constituent with CTS 6 visits of therapy were pre-authorized. This was visit #4 of 6 pre-authorized. This was visit # 4 of 6 pre-auth #711114477-1..."

Amount in Dispute: $634.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the insurance carrier representative box #17 on September 1, 2011. The DWC060 was signed by "BFS" on September 1, 2011. Therefore, a decision will be issued based on the information provided at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2010, September 7, 2010 and September 8, 2010	98943, 97110, and 97140	$634.11	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 8, 2010
   - 11 – Diagnosis inconsistent with Procedure
   - 198 – Payment adjusted for exceeded precert/preauth
   - 197 – Payment adjusted for absence of precert/preauth

Explanation of benefits dated October 21, 2010

- 197 – Payment adjusted for absence of precert/preauth

Issues

1. Did the requestor submit an initial and reconsideration bill to the insurance carrier for CPT code 97014?
2. Did the requestor obtain preauthorization and an extension for the physical therapy services?
3. Did the requestor bill for treatment that contained NCCI edit conflicts?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division... (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)..."
    - Review of the "request for reconsideration" states in pertinent part, "With respect to denial code 197, the incorrect CPT code G0283 was submitted on the original bill. CPT code 97014 - electrical stimulator was pre-authorized. I have corrected the bill to reflect 97014 and a copy of the treatment note is attached to document that the treatment that was approved is what was actually provided to patient on date of service 09/03/10."
    - Review of the initial CMS-1500's presented for review, documents that the requestor billed CPT codes 98943, 97110-GP and G0283-GP for disputed dates of service September 3, 2010, September 7, 2010 and September 8, 2010.
    - Review of the corrected CMS-1500 presented for review, documents that the requestor billed CPT codes 98943, 97110-GP and 97014-GP for disputed dates of service September 3, 2010, September 7, 2010 and September 8, 2010.
    - Review of the "Table of Disputed Services" indicates the requestor seeks reimbursement for CPT code 97014 for dates of service September 3, 2010, September 7, 2010 and September 8, 2010, however the documentation submitted for review does not meet the minimum requires of 28 Texas Administrative Code §133.307 (c)(2)(J). As a result, CPT code 97014 is ineligible for MFDR review and cannot be considered in this audit.
2. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services..."
    - The requestor disputes dates of service September 3, 2010, September 7, 2010 and September 8, 2010.
    - The requestor submitted a copy of a preauthorization letter dated August 26, 2010 documenting that the insurance carrier preauthorized physical therapy x 6 sessions (97110, 97140) with a start date of August 20, 2010 and an end date of October 20, 2010.
    - The insurance carrier denied CPT codes 98943, 97110 and 97014 rendered on September 3, 2010, September 7, 2010 and September 8, 2010 with bill comment "Please be advised this is a re-eval of Bill #1588117, Preauth #711114477 had its 6 visits met on 9-2-10."
    - Review of the documentation submitted for review does not document that the carrier provided concurrent review preauthorizing more visits. As a result, reimbursement cannot be recommended for CPT codes 97110 rendered on September 3, 2010, September 7, 2010 and September 8, 2010.
    - CPT code 98943 was not included in the preauthorization request/approval. Preauthorization is required per 28 Texas Administrative Code §134.600 and preauthorization was not obtained. As a result, the requestor is not entitled to reimbursement for CPT code 98943 rendered on September 03, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.